REVITALIZE
INFUSION CENTER

Rystiggo®

Infusion Order Form

Patient Information:

_____ _____ _____

Patient Name **DOB** **Phone Number**

Medical Information:

Primary Diagnosis:

☐ Myasthenia gravis without (acute) exacerbation ICD-10 Code: G70.00

☐ Myasthenia gravis with (acute) exacerbation ICD-10 Code: G70.01

☐ Other_____ ICD-10 Code: _____

Allergies: _____(or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis including:
- Relevant labs and tests including:
  - Anti-AChR+ Serology and/or MuSK+ serology
- Medication List
  - Documentation of previously trialed and failed therapies including most recent administration date, documentation of intolerance, contraindication or rationale for discontinuation

Height: _____

Weight: _____

Rystiggo (rozanolixizumab-noli) Orders:

Administer the ordered dose subcutaneously once weekly for 6 total doses to complete 1 cycle

Ordered Dose:

☐ 420 mg (for patients <50 kg)

☐ 560 mg (for patients 50 kg to <100 kg)

☐ 840 mg (for patients >100 kg)

Quantity of Cycles Ordered (each cycle includes 6 total doses):_____

Subsequent cycles to be initiated after _____ off-weeks*

*Recommend a minimum of 3 weeks

Pre-Medication Orders: _____

*No pre-medications are recommended based on the manufacturer's PI

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

_____ _____

Prescriber's Signature **Date**

_____ _____

Prescriber's Printed Name **Contact Phone #:**

For Information About Revitalize and or Infusion Plus, please scan the QR code below:

Revitalize Revitalize Locations InfusionPlus